large city in the United States has. What the control board now finds is that the District has had 4 years of balanced budget with a surplus and a large reserve, and this has occurred 2 years ahead of time. At the same time, the District is in the throes of a complete overhaul of its city government, including every form of service delivery. We have surpassed the wildest expectations of this body.

The same page of the Washington Times reports, Hill Chairman To Keep Riders Off of City Budget. This will be very good news to most Members of the House who have had to consider the D.C. appropriation year after year.

I appreciate that the gentleman from Michigan (Mr. KNOLLENBERG) does not want the smallest budget in the House to take virtually the most time. This year I had to get unanimous consent.

I really thank the gentleman from Illinois (Mr. HASTERT) who helped me get unanimous consent to get the District's budget out 6 weeks late, even after it was balanced and had a surplus, but the fact is that it caused a tremendous hardship to have our budget out 6 weeks ago ahead of time. This should not have come here in the first place. This is the District's money raised by the District's taxpayers. This is a terrible anomaly that that the budget comes here.

The hard work that both sides of the aisle put in still makes the Congress look bad because it takes so long to get the matter out. The District of Columbia has shown that it is prepared to uphold its end of the bargain with balanced budgets, with surpluses.

We recognize that the work is not done. This is a city that has had to put itself together again like Humpty Dumpty. I appreciate very much what the Mayor of this city and the revitalized city council has done to make this happen. Nevertheless, this is a city without a State.

I will have not some revenue, but bills on the floor for Members, but rather some notions that allow the District to build back its own tax base. Among the payment solutions I will put forward will be a tax credit that will allow the District to pay for the services that commuters use. Eight out of 10 cars in the District of Columbia come from Maryland and Virginia and outside the District. They tear up our roads and leave a diminished tax base to pay for them.

They call our fire. They call our police. They use our water and do not leave anything here. A tax credit based on the services commuters use which cost commuters nothing is the way to approach this. My colleagues do not want the District to go back down the drain, even given all the streamlining and hard work it has done to pull itself out simply because, unlike your cities and counties, we have no State to back us out.

We are not out of the woods yet, but we are way out of the hole. I come to the floor this evening to thank the Congress for what they have done to help the District get out of the hole. I think that the Congress would want to thank Mayor Anthony Williams and would want to thank the counsel of the District of Columbia for pulling themselves up by their own bootstraps.

COURT RULING ON CLASS ACT LAWSUIT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Mississippi (Mr. SHOWS) is recognized for 5 minutes.

Mr. SHOWS. Mr. Speaker, in a major legal development this past Thursday, a U.S. Court of Appeals ruled in favor of a lawsuit filed by the class act group of the military retirees.

In the case of Schism versus the United States, the court found that there is, in fact, a broken promise between the United States Government and thousands of military retirees and their families.

This suit was filed on behalf of military retirees who were recruited into the service with a promise that lifetime health care would be provided to them if they served a career of at least 20 years.

The class act represents retirees who entered the service prior to June 7, 1956. That was the day Congress enacted the first military retiree health care plan, which today we know it as Champus or TRICARE.

Enactment of those health care plans actually stripped away health care that had been promised to these recruits and which had been routinely delivered.

After June 7, 1956, statutes no longer obligated the government to provide health care to military retirees, but health care that is now provided at military bases on a space-available basis is out of reach for many retirees, due to base closures and downsizing, and that is assuming that space is available which is not always the case.

Here are a few choice quotes from the appeals court decision. The retirees entered active duty in the Armed Forces and completed at least 20 years of service on the good faith that the government would fulfill its promises.

The terms of the contract were set when the retirees entered the service and fulfilled their obligation. The government cannot unilaterally amend the contract terms now.

The government breached its implied-in-fact contract with the retirees when it failed to provide them with health care benefits at no cost.

Congress was without power to reduce expenditures by abrogating contractual obligations of the United States. To abrogate contracts, in the attempt to lessen government expenditure, would not be the practice of economy, but an act of repudiation.

The case has been remanded to a lower court to determine damages. Such damages could result in billions and billions of Federal dollars being awarded to millions of military retirees and their families, particularly if damages are rewarded to retirees who fall beyond the scope of the class act group.

What does this mean to us in Congress? The court decision validates what I had been saying since 1999 when I introduced the Keep Our Promise to America's Military Retirees Act.

The appeals court decision gives us the opportunity to act now and restore health equity to military retirees who now have the courts on their side, and we can do it without busting our budget.

We must pass H.R. 179, the Keep Our Promise Act.

It acknowledges the broken promise of lifetime health care by providing military retirees within the class act group with fully-paid Federal Employees Health Benefit Plan eligibility, and allows all other military retirees to participate in the FEHBP, just like any other Federal employee.

Mr. Speaker, but if they are happy with TRICARE, the military health plan, they can stay with it, Congress passed that part of the Keep Our Promise Act last year.

If we pass this bill, the U.S. government will have responded to the court, and we will have acknowledged and made good on the broken promise to our America's military retirees.

We must do the right thing and quickly enact H.R. 179 into law.

IN SUPPORT OF BIPARTISAN PATIENT PROTECTION ACT OF 2001

The SPEAKER pro tempore (Mr. SIMPSON). Under a previous order of the House, the gentleman from Texas (Mr. GREEN) is recognized for 5 minutes.

Mr. GREEN of Texas. Mr. Speaker, I rise today as an original cosponsor of the Bipartisan Patient Protection Act, which was introduced last week by the gentleman from Michigan (Mr. DINGELL), the gentleman from Iowa (Mr. GANSKE), Senator JOHN MCCAIN, and Senator TED KENNEDY. I am proud to be part of the bipartisan coalition that hopefully will finally enact a strong Patients' Bill of Rights.

Mr. Speaker, Americans have been clamoring for a Managed Care Reform for a number of years. They want Congress to enact legislation that puts medical decision-making back in the hands of doctors and patients. They want legislation that provides meaningful accountability. In short, they want the Dingell-Ganske Bipartisan Patient Protection Act of 2001.

This legislation provides patient protections that are very similar to those that have been the law in my home State of Texas since 1997.

A recent article in Texas in the magazine ''Texas Medicine'' outlines the success of the independent appeals process as part of the HMO reform. As the article references, a provision of the law has been particularly effective in providing patients with real protections.

When the Texas legislature passed Managed Care Reform in 1997, it included an external appeals provision allowing patients to appeal the decisions of their health care plans. These appeals are not brought through expensive and time-consuming legislation but through quick reviews by State-certified independent review organizations called IROs.

IROs are made up of experienced physicians who have the capability and authority to resolve disputes for cases involving medical judgment. Their decisions are binding on both the patients and the plans.

These provisions have been successful, not only because they protect patients, but also because they protect the insurers. Plans that comply with the IRO's decision cannot be held liable for punitive damages. So if a decision goes against the patient, that patient can still go to court. But we will talk about that later on the lack of litigation under the Texas laws since 1997.

This plan has worked real well. Since 1997, more than 1,000 patients and physicians have appealed the decisions of the HMOs. The independence of the process is demonstrated by the fairly even split in the decisions resulted. In 55 percent of the cases, the independent review organizations, the IRO, fully or partially reversed the decision of the HMO. So in 55 percent of the cases, they were found for the patient or the physician than the original decision.

Now, during the debate on HMO reform in Texas, there was concern that managed care reform would be very costly and would lead to a flood of unnecessary and expensive litigation. But that has not been the case in Texas. To my knowledge, less than five cases have been filed since patients' protection became law in 1997.

I believe that the external appeals process has been instrumental in the success of the Texas plan and has given patients what they really want, access to timely quality medical care while protecting insurers from costly litigation.

The process works so well that, despite the U.S. Fifth Circuit Court of Appeals ruling that the external appeals were in violation of the ERISA, Aetna and other HMOs agreed to voluntary submit disputes to the IROs for resolution.

Finally, Mr. Speaker, I would like to point out that these protections have not lead to dramatic premium increases as some of our naysayers said. In fact, in Texas, the premium increases have been consistent with, and in some cases actually lower than premium increases in other States with substantially weaker patient protections.

Mr. Speaker, it is time for Congress to enact a Bipartisan Patient Protection Act. Our President is supporting it. Hopefully we will be able in the House and the Senate to put a plan together that will give patients the protections that they need. I urge my colleagues to join me in supporting it.

Mr. Speaker, I include the article from the magazine ''Texas Medicine'' that I referenced earlier as follows:

[From Texas Medicine, Jan. 2001]

SECOND-GUESSING THE INSURERS

INDEPENDENT REVIEW PROCESS APPEARS TO BE WORKING

(By Walt Borges)

Since late 1997, more than 1,000 Texas patients and physicians have challenged decisions of health maintenance organizations (HMOs), insurance companies, and third-party administrators (TPAs) to deny payments for treatments that the insurers deemed medically unnecessary or inappropriate. The challenges were not brought through expensive and time-consuming litigation, but through quick reviews conducted at no cost to patients and physicians by three state-certified entities known as independent review organizations (IROs).

A Texas Medicine analysis of Texas Department of Insurance (TDI) statistics covering the first 2½ years of the IRO system's operation found that the IROs reversed insurers' decisions in whole or in part in more than 57 percent of the 1,007 cases that were reviewed.

HMOs' decisions were reversed or modified in 55 percent of the 515 reviews, while decisions by insurance companies and TPAs were overruled in 60.5 percent of 481 reviews. Eleven other reviews were for health care entities that did not have an identifiable status in the TDI databases.

Even though the TDI databases can be analyzed to show how individual insurers fared in independent review, the findings offer limited insights into the quality of care and decision-making because of large variations in the number of reviews of each health care entity. Attempts to index the reversals to claims or covered lives failed because of variations in enrollment over the three-year period and because TDI does not track the number of policyholders for health insurance companies.

''There are a huge number of patients and a huge number of claims, so reversal rates are tiny,'' said Paul B. Handel, MD, of Houston, chair of Texas Medical Association's Council on Socioeconomics. ''But only 8 to 10 percent of the cases involve areas [of treatment] where the patients need the [extensive] technology and medication. We should be looking at how that population fares.''

IROs were a key feature of a law passed by the Texas Legislature in 1997 that gave Texas health plan members the right to sue their HMOs for denying medically necessary treatments. But unlike that controversial provision, which acted as a lightning rod for insurance industry opposition and prompted lawsuits claiming it conflicted with federal law, establishment of independent reviews drew the public support of consumer advocates, insurers, and doctors alike.

In June, a three-judge panel of the U.S. 5th Circuit Court of Appeals in New Orleans upheld provisions authorizing suits against managed care organizations. However, the court ruled that independent reviews of HMO decisions violated the Employee Retirement Income Security Act (ERISA), the federal law that reserves regulation of employer-funded benefit plans to Congress.

But the appeal of the IRO process is such that Aetna, whose subsidiaries filed the suit, and other major HMOs announced after the decision that they would continue to voluntarily submit disputes to the IROs for resolution. That came well before TDI told insurers and health plans that it would consider the system intact until the completion of court rehearings and appeals.

Despite popular support for IRO process, some physicians and IRO officials think many questionable decisions have been left unchallenged because of a lack of public knowledge that the system exists.

''The sense is that doctors and patients are not really aware of the IRO process,'' said Dr. Handel. ''This is something we've talked about at the council level.''

Gilbert Prudhomme, secretary director of Independent Review Inc., one of the Texas IROs, said he was ''absolutely astounded how few people know about it.'' Mr. Prudhomme says that as recently as last summer the insurance department at The University of Texas M.D. Anderson Cancer Center was unaware of the IRO process.

''A lot of people think ERISA preempts the system,'' said Mr. Prudhomme. ''They tell me they didn't know if it was still valid or they thought it had stopped working. There's a cloud over it by virtue of the ERISA controversy.''

IRO official Kathryn Block, administrator of Envoy Medical Systems, said, ''The hospitals don't understand what we are. They seem to think we're some kind of insurance company when we ask for records.''

REVERSAL RATES OF IROS

[December 1997 to August 2000]

IRO	Appeals	Upheld	Reversed	Partial	Percent reversed	Percent reversed (total and partial)
Texas Medical Foundation	652	308	301	43	46.17	52.76
Envoy Medical Systems	273	98	159	16	58.24	64.10
Independent Review Inc.	82	25	46	11	56.10	69.51
Total	1,007	431	506	70	50.25	57.20

HOW IT WORKS

Texas was the first state with external review of medical necessity decisions. Thirty-seven states now have a review process. Under Texas law, a patient may seek review by an IRO if a health insurer refuses to pay for treatment it considers to be medically unnecessary or inappropriate. Patients or their physicians also my request IRO reviews of denial of treatments that are recommended but not yet performed. Doctors cannot authorize the release of the medical records needed for the review, however. Only the patient or a guardian may sign the release form.

In most cases, the health plan's internal appeals process must be used before requesting an IRO appeal, Denial of treatment for

conditions that patients or doctors believe are life-threatening may lead to a bypass of the insuer's internal appeals process.

The IRO process is not always available. A complaint to TDI and/or an internal appeal to the health plan over the denial of payment is the only challenge permitted when treatment already has been provided and the insurer determines it was not necessary or appropriate, or when payment for a service not covered by the plan is denied. IRO appeals also are not available when Medicaid, Medicare, or a Medicare HMO provides a patient's health coverage.

Insurers pay $650 for each review if the review is provided by a physician and $460 if it comes from other health care professionals, e.g., dentists, optometrists, and podiatrists. The decision of the IRO is binding on the health plan or insurer.

Under TDI rules, ''the utilization review agent that forwards an independent review request to TDI pays the IRO that does the work,'' said TDI's Blake Brodersen, deputy commissioner for HMOs. ''We believe that the utilization review agents generally pass this cost through to the health plans themselves. The IROs are certified by TDI after we're satisfied they meet all certification requirements contained in our rules. They do not, however, contract with TDI.''

BUT DOES IT WORK?

There is general agreement among regulators, IRO officials, and health insurers that the system is working relatively well for those who seek reviews.

''It's working very well and as the legislature intended,'' said Insurance Commissioner José Monetmayor. ''The legislature wanted a system of truly independent review, one in which there were no foregone conclusions to favor health plans or to favor patients. The independence of the process is demonstrated by the roughly 50–50 split between decisions upholding and decisions reversing adverse determinations by health plans.''

Phil Dunne, chief executive officer for the Texas Medical Foundation (TMF), the first IRO certified by the state, said, ''From TMF's perspective, the process appears to be working in accordance with the statute and regulations. The various organizations involved in appeals have been compliant and cooperative.''

Mark Clanton, MD, chief medical officer of Blue Cross and Blue Shield of Texas, agrees. ''The process of independent review appears to be working as intended in that it provides an independent source of review for both consumers and health plans,'' he said. ''Other than the additional cost of paying for the appeals, the process is not burdensome; the additional review provides members with additional choice.''

Mr. Brodersen said TDI has received ''no complaints that the process is burdensome to doctors. We have received a few complaints from health care plans that we allow too short a time for them to get patient records to the IROs.''

He says he reviews completed between Nov. 1, 1997, and Oct. 31, 2000, could not have cost the health care plans more than $718,250, ''plus the cost of copying medical records. Obviously the plans incur other costs, such as those for personnel time and shipping records. But nobody has attempted to estimate these.''

Lisa McGiffert of Consumers Union wonders whether patients and physicians underutilize the system. Like Dr. Handel, she is troubled by what she perceives as a lack of public knowledge. She suggests that ''the state has the responsibility to get individuals to know about the process. It needs to be proactive in getting the information out.''

Insurers and third-party administrators (TPAs) with the greatest number of IRO reviews

[November 1997 to August 2000]

Insurer	Other names	Type	Reviews completed	HMO decisions reversed
Employers Health Insurance		Insurer	115	73
Blue Cross Blue Shield of Texas		Insurer	94	52
American Medical Security		TPA	23	11
The Prudential Insurance Company of America		Insurer	19	6
PM Group Life Insurance Company		Insurer	18	4
Texas Health Management Services		TPA	17	9
CORPHEALTH, Inc.		TPA	16	6
Aetna U.S. Health Care	Aetna, Aetna Life Insurance Company and Affiliates	Insurer	13	4
CIGNA Behavioral Health		TPA	10	9
Subtotal			325	174
Total for 64 other insurers and TPAs			156	74
Totals			481	248

Insurers that deny payment for what they believe are unnecessary or inappropriate treatments are required by TDI to notify the patient that the IRO process exists twice in the preauthorization process. But Ms. McGiffert notes that the IRO process may appear to be just another frustrating step to many patients who already have exhausted two levels of insurers' internal appeals.

Patients can be discouraged by multiple denials, she says. ''They've been denied, they've appealed, and they've been denied again. Why would they think the next one would be any different?''

MEASURING QUALITY OF CARE

The results of the independent reviews were compiled from TDI databases. More than 230 records had obvious problems: For example, HMO names were accompanied by insurance company designations. Because the underlying records of the reviews are not available to the public, TDI, at Texas Medicine's request, corrected the questionable records by looking at the records of each review.

Texas Medicine split the 1,007 IRO decisions into two groups for analysis. The first included the HMOs, while the second included insurance companies and TPAs.

Overall, denials by insurance companies and TPAs were overturned 52 percent of the time, while IROs ruled the HMOs made the wrong decision 49 percent of the time. (See accompanying tables, pages 32–35.)

However, 43 of 481 decisions involving insurers and TPAs were partially reversed and partially upheld by the IROs. Adding those figures into the mix yielded a full-and-partial reversal rate of 55 percent. Similarly, 30 of 515 of the HMO reviews resulted in full-and-partial reversals, for a mixed reversal rate of 60.5 percent.

The overall reversal rates and those listed for individual companies say little about the overall quality of medical care or of individual decisions to deny treatments, IROs and insurers agree.

''The relatively small number of external appeals, when compared with the millions of members and claims that go through the system, reaffirms that there is no large-scale problem with how plans apply their medical policy or how the internal mechanism for reviewing member appeals works,'' said Dr. Clanton. ''The principal conclusion is that the quality of care remains very high in HMOs. Only 515 appeals were filed, compared with millions of claims that were paid according to member contracts. Further, only half of the number appealed were reversed.''

The numbers ''would probably not provide statistically significant conclusions,'' Mr. Dunne said.

''It is important to note that IRO review is not a quality-of-care review,'' Mr. Dunne wrote in a response to Texas Medicine's questions. ''The IRO is asked to determine if the care is medically necessary, medically appropriate for the setting of care, and/or timely (e.g., determining if other, less invasive clinical interventions should be exhausted prior to implementing the treatment plan that is being appealed).''

Upheld	Split	Pending	Percent reversed	Decisions fully or partially reversed
37	5	3	63.48	67.83
34	8	1	55.32	63.83
9	3	1	47.83	60.87
11	2	0	31.58	42.11
9	5	0	22.22	50.00
6	2	0	52.94	64.71
7	3	3	37.50	56.25
6	1	1	30.77	38.46
1	0	0	90.00	90.00
120	29	9	53.54	62.46
68	14	2	47.44	56.41
188	43	11	51.56	60.50

GOOD COMPANIES AND BAD COMPANIES?

Texas Medicine's review of the IRO appeals outcomes did not analyze how each of the Texas IROs handled the reviews of individual insurers, TPAs, and HMOs. But Ms. McGiffert suggested that annual trends sometimes show wide disparities in reversals from the 50–50 rate the insurers and regulators are prone to cite.

TDI also puts some faith in the outcomes of reviews. ''We monitor reversal rates along with the complaint statistics of individual companies,'' said Mr. Brodersen. ''On occasion, a high reversal rate has been one of the factors that led us to perform quality-of-care examinations on particular companies.''

But he also noted, ''When you consider the huge number of medical necessity decisions that HMOs make each day, approximately 600 reversals over a three-year period suggests that, overall, the quality of care provided by HMOs is very good.''

Officials with Envoy, which receives one of every three referrals from TDI, say that a short-term analysis gives a different picture than a long-term statistical analysis.

Daniel Chin, managing director of Envoy, and his administrator, Ms. Block, say they were initially asked to review large numbers of physical medicine cases during the year-plus period they have conducted reviews.

''Then all of a sudden, it was all psychological treatment cases,'' said Mr. Chin. ''Now it seems we're getting physical medicine cases again.''

IRO CONSISTENCY

One analysis conducted by Texas Medicine was of the reversal rates of the IROs. (See ''Reversal Rates of IROs,'' page 31.) TMF had a reversal rate of 53 percent when both full and partial reversals were taken into account. Envoy reversed 64 percent of the decisions, and Independent Review Inc. reversed partially or fully 70 percent of the insurers' decisions.

Does this suggest that the IRO process is inconsistent? Not more than is expected when physicians exercise their

RESULTS OF IRO REVIEWS OF HMO DECISIONS

[November 1997 to August 2000]

HMO	Other names in TDI database	Current affiliation	Current covered lives	Reviews completed	HMO decisions reversed	Upheld	Split	Pending	Percent reversed	Percent with some reversal
Magellan Behavioral Health			625,463	3	2	0	1	1	66.67	100.00
Aetna U.S. Healthcare Inc	Aetna Health Plan.		443,381	37	17	16	4	2	45.95	56.76
Aetna U.S. Healthcare of North Texas Inc			415,417	18	11	6	1	0	61.11	66.67
Texas Gulf Coast HMO Inc	NYLCare Healthcare Plans of the Gulf Coast; NYLCare Healthcare Plans	Owned by Blue Cross and Blue Shield of Texas	407,328	71	30	38	3	3	42.25	46.48
Prudential Healthcare Plan Inc	Prudential Healthcare.		344,334	72	36	35	1	3	50.00	51.39
United Healthcare of Texas Inc	United HealthCare; United Behavioral Health		315,417	33	20	11	2	1	60.61	66.67
Humana Health Plan of Texas Inc	Humana; Humana Health Plan; Humana/PCA Health Plans of Texas; Humana Health Plans.	Humana merged with Employers Health in 1997	240,371	93	48	43	2	0	51.61	53.76
Harris Methodist Texas Health Plan	Harris Methodist Health Plan; Harris Health Plan; Harris Methodist Health Inc.; Harris Methodist Health.		197,058	7	5	2	0	1	71.43	71.43
PacifiCare of Texas	PacifiCare	Part of PacifiCare of Texas	186,103	45	20	22	3	0	44.44	51.11
Southwest Texas HMO Inc	NYLCare Health Plans of the Southwest	Owned by Blue Cross and Blue Shield of Texas	169,438	17	6	6	5	0	35.29	64.71
Rio Grande HMO	HMO Blue-El Paso; HMO Blue-West Texas; HMO Blue-Northeast Texas; HMO Blue-Southeast Texas; HMO Blue-Southwest Texas; HMO Blue/formerly NYLCare of the Gulf Coast.	Owned by Blue Cross and Blue Shield of Texas	148,702	4	1	2	1	0	25.00	50.00
Scott & White Health Plan	Scott and White.		121,275	9	6	3	0	0	66.67	66.67
CIGNA Healthcare of Texas Inc	CIGNA Behavioral Health; CIGNA Healthcare of Texas-North Division; CIGNA Healthcare of Texas-South Texas Division.		114,264	4	3	0	1		75.00	100.00
Texas Health Choice LC			104,171	2	2	0	0	0	100.00	100.00
Memorial Sisters of Charity HMO LLC		Now part of Humana	90,984	13	8	5	0	0	61.54	61.54
SHA LLC	FIRSTCARE Southwest Health Alliances.		49,097	4	1	3	0	0	25.00	25.00
One Health Plan of Texas, Inc			42,785	2	1	1	0	0	50.00	50.00
Methodist Care Inc			40,363	40	13	24	3	0	32.50	40.00
AmeriHealth of Texas			37,743	2	0	1	1	0	0.00	50.00
Community First Health Plans Inc			10,898	1	1	0	0	0	100.00	100.00
Amil International (Texas) Inc			8,108	1	0	0	1	0	0.00	100.00
Healthplan of Texas Inc	Heritage Health Plans		7,266	11	6	4	1	0	54.55	63.64
Amcare Health Plans of Texas Inc	Foundation Health, A Texas Health Plan		4,931	6	4	2	0	0	66.67	66.67
Healthfirst HMO Inc	HealthFirst HMO; Healthfirst	Merged with AmeriHealth of Texas	0	13	8	5	0		61.54	61.54
AmeriHealth HMO of North Texas	AmeriHealth HMO Texas; AmeriHealth HMO.		0	5	3	2	0	0	60.00	60.00
Anthem Health Plan of Texas	Anthem Group Services Corporation	Merged with AmeriHealth of North Texas	0	1	1	0	0		100.00	100.00
Healthcare Partners HMO		Merged with Healthfirst HMO	0	1	1	0	0	0	100.00	100.00
Principal Health Care of Texas, Inc		Merged with United HealthCare	4,124,897	515	254	231	30	11	49.32	55.15

independent judgment on clinical problems, say regulators and IRO officials.

''The IROs, by definition, are independent,'' said Mr. Bordersen. ''However, each must do its review in conformity with TDI requirements. We monitor processes, not results, and at the present time we are satisfied that each IRO is doing its work in accordance with our rules.''

Mr. Dunne points out that the larger number of reviews conducted by TMF could account for the discrepancy in reversal rates.

Ms. McGiffert says the discrepancy in reversal rates is not unexpected, as physicians will make judgments that differ. She says that TMF, which tends to have a more clinical approach than the other two IROs, sometimes suggests other alternatives for treating conditions that led to denied claims, which she thinks is helpful to patients. TMF officials say they may mention more conservative treatment options in the clinical rationale they provide in upholding insurer decisions, but they do not suggest treatment alternatives.

Dr. Handel say TMF's approach is appreciated. ''My sense is that the patient may be benefiting from their suggestions. A purely administrative type of appeal may not benefit the patient as much.''

Ms. Block noted that Envoy uses doctors who exercise clinical judgment in their reviews, but they do not propose treatment alternatives because that is not the function of the review process.

Mr. Prudhomme says physicians who conduct the reviews for Independent Review Inc. are encouraged to refrain from suggesting alternatives, unless it is obvious from the records that another course of action would benefit the patient.

CENSUS DATA MUST BE ACCURATE

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise to voice my concern regarding the story, which appeared in last Thursday's Wall Street Journal titled ''Bush's Next Recount Battle: Should Census Tallies Be Adjusted''. The story relays President Bush's assurances to House Republicans to put the ''fix on the Census'' by not including sampling figures in those numbers used to redraw Congressional District lines.

This nation has already gone through one trauma related to the lack of accuracy in counts and the struggle to include every